

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

10126

Do not use this space.

## 1. PLACE OF DEATH

(a) County Benton Registration District No. 61  
(b) Township W. 5th Primary Registration District No. 3096  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S. if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

(a) Residence, No. 163 Charles Shupert St. Warsaw Mo. Rural  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 24 / 1870

7. AGE YEARS 69 MONTHS 70 DAYS 11 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 2725

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warsaw Mo

FATHER 13. NAME Charles Shupert

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnson Co. Mo

MOTHER 15. MAIDEN NAME do not

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Mr. V. Beck  
Warsaw Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE National DATE Mar 20 19 40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. M. White  
Warsaw Mo

20. FILED 3/20 19 40 Jas. A. Logan  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 19 19 40

22. I HEREBY CERTIFY, That I attended deceased from 3-18 19 40 to 3-19 19 40

I last saw him alive on Mar 19 19 40 Death is said to have occurred on the date stated above, at 3 P.M.  
The principal cause of death and related causes of importance were as follows:

Fecal infection

Other contributory causes of importance:

septic infection from tonsils and kidneys

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis Clinical Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) J. R. Smith M. D.

(Address) Warsaw Mo

RECEIVED

District Health Officer No. 7,

District File Number. 4-40-529

Date Filed 4-2-40

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10126

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 61

Primary Registration District No. 3096

Registrar's No.

1. PLACE OF DEATH:

(a) County Benton  
(b) City or town Warsaw  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME

Charles Shipert

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex m 5. Color or race w 6. (a) Single, wid, married, divorced Div

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive year

7. Birth date of deceased mar - 24 - 1890  
(Month) (Day) (Year)

8. AGE Years 69 70 Months 11 Days 25 If less than one day in min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5/1/40 (b) JAS A. Logan (Distinguishing local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Benton  
(c) City or town Warsaw MO (Rural)  
(If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U.S.A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month mar day 19 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw h. alive on and that death occurred on the date and hour stated above. Immediate cause of death.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature J.P. Smith (M. D. or other) Address Warsaw

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

5-10126